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WORKING WITH DISABILITY: WORK AND INSURANCE IN BRIEF

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What Is the Demonstration to Maintain Independence and Employment (DMIE) and Who Is Participating?

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The Demonstration to Maintain Independence and Employment (DMIE), a grant program administered by the Centers for Medicare & Medicaid Services, awards funds to states to develop, implement, and evaluate interventions that are intended to improve health care coverage and employment services for working adults with potentially disabling conditions such as diabetes and mental illness. Authorized by the Ticket to Work and Work Incentives Improvement Act of 1999, the DMIE allows states to provide Medicaid-equivalent coverage or "wrap-around" coverage, which supplements existing health insurance. They also may offer employment-support and case management services that increase the likelihood of sustained employment. Four states were approved as of June 2007 under the most recent DMIE solicitation—Hawaii, Kansas, Minnesota, and Texas.[1]

This issue brief, the sixth in a series on workers with disabilities, reviews the rationale for the DMIE, the interventions in the four most recent DMIE states, the DMIE evaluation, and next steps in disseminating information about the effects of these innovative demonstration projects.

Rationale for the DMIE

Many workers with potentially disabling health conditions reach a point at which they can no longer work and must rely on federal disability benefits. The ensuing policy question is: if these workers had access to a comprehensive package of health care services and employment supports, could they have postponed, or avoided the need for, disability benefits? The DMIE is intended to address this question by testing whether new ways to improve access to health care and employment services for workers with potentially disabling health conditions can prolong employment and promote independence from federal disability benefits.

The majority of working-age Americans obtain health care coverage through an employer-sponsored private health insurance plan. While 81 percent of nondisabled working-age Americans are covered by such plans, the same is true for only 55 percent of those with disabling impairments (Steinmetz 2006). This disparity is attributed partly to the risk of higher health care costs that comes with disabling conditions. Employers who

provide private health insurance often reduce their liability for these costs by offering plans with limited benefits, higher deductibles, and more cost-sharing. Small employers may decide not to provide health insurance at all. As a result, it can be difficult, if not impossible, for people with potentially disabling conditions to access the health care services they need through private insurance to continue working.

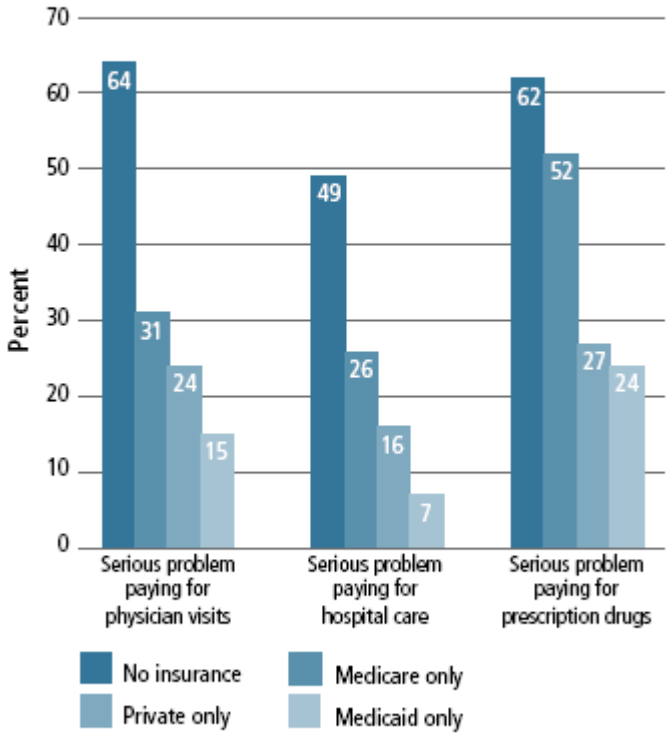
A second path to coverage is to enroll in Medicare or Medicaid. But that is easier said than done. To join these public programs, nonelderly individuals with potentially disabling conditions must meet the eligibility criteria for the disability programs funded by the Social Security Administration (SSA). These criteria include the inability to work at a level referred to as "substantial gainful activity" (SGA) because of a health condition that is expected to last at least 12 months or result in death. Medicare or Medicaid coverage may therefore not be an option until a potentially disabling condition becomes a severe work disability. Furthermore, access to public health insurance can be limited for other reasons: Medicare is available for nonelderly individuals who qualify for Social Security Disability Insurance (SSDI), but only after a two-year waiting period; and in most states, Medicaid coverage is limited to those who meet strict income and asset limits.

In sum, the coverage options for working-age Americans with potentially disabling health conditions who want to work but need health care services to do so add up to a "Catch-22." On one hand, their health conditions can make it difficult to find comprehensive, affordable private health insurance. On the other hand, public health insurance is usually available only when a health condition becomes a work-limiting disability. The result is a deterioration in health that might have been prevented, a premature exit from the labor market, and greater reliance on disability benefits. Once a person starts to receive benefits, he or she is likely to depend on them for a long time.

Policymakers have begun to address this problem by expanding access to Medicaid for workers with disabilities. This approach makes sense because, compared to private insurance or Medicare, it has more potential for increasing access. Results from the Kaiser Disability Survey (Figure 1) show that individuals with Medicaid coverage have less trouble accessing services than do those with Medicare or private insurance. More specifically, they are less likely to report having trouble paying for physician visits, hospital care, or prescription drugs.[2]

One way that policymakers have expanded access to Medicaid is through state Medicaid Buy-In programs, which allow workers with disabilities who meet SSA's medical disability criteria to "buy into" the Medicaid program by paying a modest premium. The majority of Medicaid Buy-In participants are SSDI beneficiaries who are working. The DMIE interventions differ from the Buy-In programs in that they provide a more comprehensive set of services to workers with potentially disabling conditions who are not receiving any federal disability benefits.

Figure 1. Percentage of individuals reporting problems accessing health care and related services in 2003, by insurance coverage



Source: 2003 Kaiser Disability Survey results reported in Hanson et al (2003)

State DMIE Interventions

Each state DMIE intervention targets a different subgroup of people with conditions ranging from mental illness and diabetes to multiple pre-existing conditions (Table 1). Each intervention also has several components, including enhanced health care coverage, employment-related support, and case management. All participants are randomly assigned to either a treatment group, which receives DMIE services, or to a control group, which receives existing services.

Kansas. The Kansas DMIE targets working individuals in the state's high-risk insurance pool who have pre- existing health conditions. Relative to the standard benefits in the high-risk pool, the intervention offers three main advantages: (1) lower out-of-pocket costs via lower co-payments and the elimination of high deductibles (up to $10,000), with an estimated minimum savings of $550 per month; (2) benefits that go beyond Medicaid services, including home visits for help with personal care, exercise training, and ergonomic assessments; and (3) case management, which helps participants decide which benefits best meet their needs. The sample for the DMIE in Kansas is expected to include 200 people randomly selected for the treatment group and another 200 for the control

group. Recruitment began in April 2006, and 353 people were participating in the DMIE as of June 28, 2007.

Minnesota. The Minnesota DMIE targets working individuals with severe mental illness who live in Hennepin, Ramsey, and rural northern counties. The intervention provides the following health benefits and employment support services: (1) comprehensive medical and behavioral services; (2) employment-related support with a "wellness navigator," who performs a needs assessment and develops an individual employment plan; (3) employment and peer support services; and (4) telephonic Employment Assistance Program services. The DMIE sample is expected to include 1,500 people randomly selected for the treatment group and 500 people randomly selected for the control group. Recruitment began in December 2006, and 158 people were participating in the DMIE as of June 28, 2007.

Texas. The Texas DMIE targets working adults enrolled in the Harris County Hospital District medical program for uninsured residents. Eligibility criteria include being diagnosed with (1) a severe mental illness (schizophrenia, bipolar disorder, major depression) or (2) a less severe mental illness (anxiety disorder, depression) or a substance abuse disorder co-occurring with a physical diagnosis (e.g., diabetes), thus making SSI or SSDI eligibility more likely. The intervention will provide (1) enhanced medical, mental health, chemical dependency, and dental services; (2) better access to mental health services; (3) case management; and (4) employment-related support. The DMIE sample is expected to include 800 people randomly selected for the treatment group and 625 people randomly selected for the control group. Recruitment began in April 2007, and 292 people were participating as of June 28, 2007.

Hawaii. The Hawaii DMIE targets working adults with diabetes in a select number of mid-sized and large employer groups in both the city and the county of Honolulu. Employers will be important partners in building community awareness of the demonstration. The intervention will provide a menu of services, including (1) pharmacist counseling on medication therapy management; (2) Life+Work coaching to support the achievement of personal goals; and (3) a variety of wellness services including a nutritionist, a fitness trainer, and a counselor certified in diabetes management. The DMIE sample is expected to include 267 people randomly selected for the treatment group and 267 people randomly selected for the control group. Recruitment is expected to begin in September 2007.

Table 1. DMIE Study Populations and Interventions, by State

State (Start Date)	Study Population (Enrollment Target)(*)	DMIE Intervention
Kansas (April	Employed individuals who are enrolled in the	Includes services that "wrap around" existing high-risk insurance pool benefits.

2006)	statewide high-risk insurance pool. (T=200, C=200)	Advantages relative to standard high-risk pool benefits include (1) lower out-of-pocket costs ($550 per month) from eliminated deductibles and lower co-payments for existing high-risk pool benefits; (2) "enhanced" benefits beyond Medicaid (e.g., home visits for personal care, exercise training, ergonomic assessments); and (3) case management.
Minnesota (December 2006)	Employed adults with severe mental illness in three counties. (T=1500, C=500)	Includes (1) employment-related support with a "wellness navigator," who performs a needs assessment and develops an individual employment plan; (2) comprehensive medical and behavioral services; (3) employment and peer support services; and (4) telephonic Employment Assistance Program services.
Texas (April 2007)	Employed adults in Harris county with either a severe mental illness or a behavioral diagnosis co-occurring with a physical diagnosis. (T=800, C=625)	Includes (1) enhanced medical, mental health, chemical dependency, and dental services; (2) better access to mental health services; (3) case management; and (4) employment-related support.
Hawaii (June 2007)	Employed adults with diabetes in both the city and the county of Honolulu. (T=267, C=267)	Includes a menu of services as follows: (1) pharmacist counselors, who provide medication therapy management; (2) Life+Work coaches, who support the planning and attainment of personal goals; and (3) wellness services consisting of a nutritionist, fitness trainer, and diabetes management counselor.

Source: DMIE state evaluation protocols and correspondence with DMIE state project directors.
*T= estimated size of treatment group, C = estimated size of control group

DMIE Evaluation

The DMIE is being evaluated at both the state and the national level during program operation and after it ends in 2009. Each state must design and conduct a rigorous evaluation of its intervention’s impact on three outcomes: health status, employment status, and reliance on cash benefits. In its solicitation, CMS emphasized the importance

of a strong evaluation design. All four states went on to propose a random assignment design, which will generate the soundest possible evidence of the DMIE's impact on the three core outcomes.

In addition to collecting data specific to their interventions, the states have agreed to collect data on the same participant characteristics and outcomes. Under contract to CMS, Mathematica Policy Research (MPR) will compile this information into a Uniform Data Set (UDS). MPR will then enhance the UDS by adding the following data to its analysis of DMIE impacts: (1) Medicaid utilization and spending data from the CMS Medicaid Analytic Extract data files, (2) annual earnings from SSA's Master Earnings File, and (3) SSI/SSDI participation data from SSA. Together, the UDS data, the CMS data, and the SSA data will provide a comprehensive picture of the DMIE population and the extent to which it is affected by the interventions.

Next Steps

Over the next two years, all DMIE states will be offering intervention services and collecting data for their own evaluations and for the national evaluation. Beginning in the spring of 2008, MPR will produce annual interim reports on the DMIE and, in 2010, MPR will submit a final report to CMS on the national findings. The results will provide new evidence on whether enhanced health care and employment supports for workers with potentially disabling conditions improve health status and quality of life, sustain employment, and reduce dependence on disability benefits—in the short term. The results will also provide information on the potential long-term impact of the DMIE on these outcomes. Armed with this knowledge, policymakers will have the best evidence to date for designing programs that will improve the lives of people with potentially disabling health conditions.

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[1] Four states were approved under previous solicitations. Rhode Island was approved but did not implement the demonstration. In Mississippi, enrollment was limited to fewer than 50 participants. Louisiana was poised to implement the project when Hurricane Katrina struck, forcing a major reallocation of budget priorities. The District of Columbia implemented its program without a formal evaluation effort, so few systematic data are available to analyze program effects. At least one addi tional state is in the process of submitting a DMIE proposal.

[2]The data for the figure were collected before the Medi-care prescription drug benefit (Part D) was introduced. It is possible that these problems have been reduced since then, but data on the issue are not yet available.